



**Department
of Health**

Integrated Primary Care Value Based Payment Arrangement

Measurement Year 2019 Fact Sheet



Integrated Primary Care Value Based Payment Arrangement

This fact sheet has been prepared to assist payers and providers to more thoroughly understand New York State's Medicaid Integrated Primary Care (IPC) Value Based Payment (VBP) Arrangement. It provides an overview of the Arrangement including, a summary of the components of care, the underlying episodes of care and the categories of measures recommended for use in IPC Arrangements.

Introduction

The IPC VBP Arrangement is designed to incentivize Primary Care Providers (PCPs) to collaborate with behavioral health and other specialty medical and community-based providers to improve the quality of preventive care, care for chronic conditions and sick care for New York State (NYS) Medicaid patients. Although the services included in an IPC Arrangement constitute a significant portion of the total cost of care for patients, the risk in this Arrangement is limited to the provision of services that most PCPs would consider to be within their control (i.e. preventive care, sick care and the most prevalent chronic conditions in the NYS Medicaid population).

The IPC Arrangement provides an impetus for significant investment in integrated primary care and facilitates the movement toward the provision of Advanced Primary Care (APC) in NYS. Savings in an IPC contract are primarily achieved through reductions in downstream costs: expenditures for sick care and chronic care from hospital utilization that would be reduced when integrated primary care is functioning optimally.

This fact sheet provides an overview of NYS's VBP IPC Arrangement and is organized into three sections:

- Section 1: Describes the types of care included in the IPC Arrangement and the method used to construct the episodes of care;
- Section 2: Describes the quality measure selection process and the categories of measures recommended for use in IPC Arrangements; and,
- The Appendix contains a glossary of terms used in this document.

Section 1: Defining the IPC Arrangement Episodes of Care

The IPC Arrangement: Three Distinct Components of Care

In the IPC Arrangement, the Medicaid Managed Care Organization (MCO) contracts with a provider organization for integrated primary care services, such as an Independent Practice Association (IPA), which may include Patient Centered Medical Homes (PCMH), Advanced Primary Care (APC) practices or other PCPs. The IPC Arrangement includes three distinct components of care. Each component of the Arrangement consists of episodes of care or groups of clinically related services delivered by physicians, other licensed practitioners and ancillary providers across all settings of care during a pre-defined period.

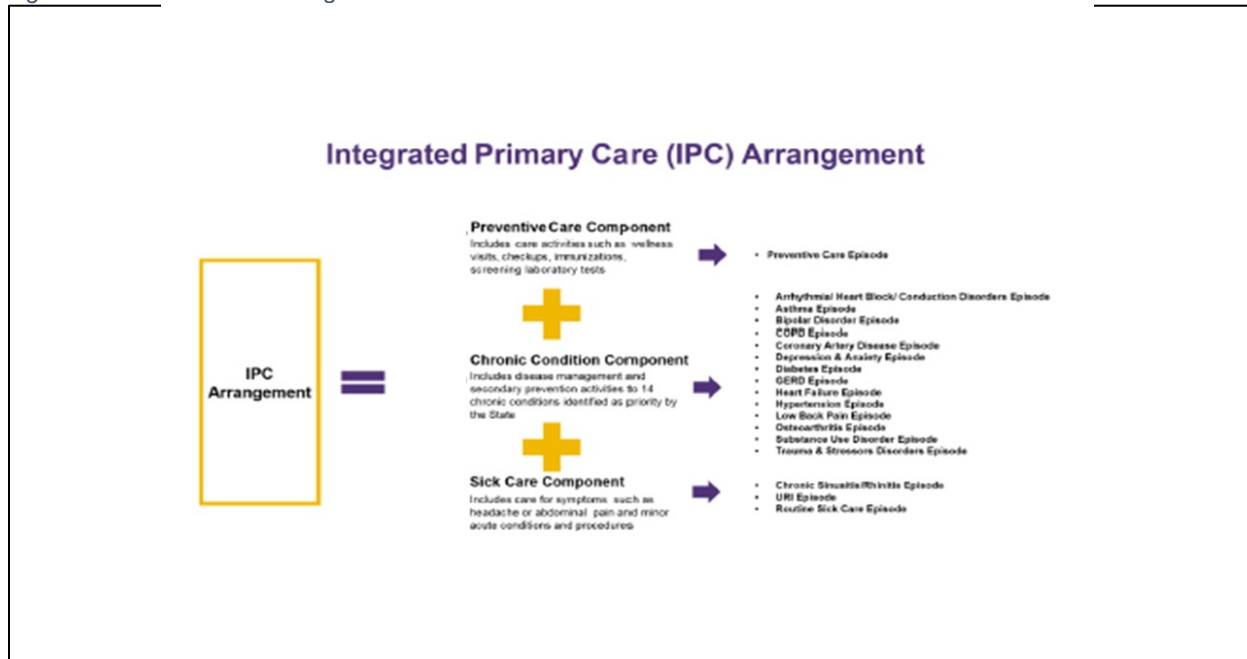
As illustrated in Figure 1, the IPC Arrangement consists of the following three components and underlying episodes:

1. The Preventive Care component consists of a single episode (the Preventive Care episode);

2. The Chronic Condition component consists of 14 unique chronic condition episodes; and,
3. The Sick Care component includes three episodes: the Upper Respiratory Infection episode, the Allergic Rhinitis/Chronic Sinusitis episode, and the Routine Sick Care episode.

Together, the three components of the IPC Arrangement include 18 unique underlying episodes of care that reflect a focused subset of the integrated primary care services delivered to attributed patients during the contract year (see *Figure 1*).

Figure 1: NYS VBP IPC Arrangement



Constructing the IPC Arrangement Episodes of Care: Trigger Events, Time Windows and Services

The episodes of care included in the IPC Arrangement are constructed using a set of rules based on the PROMETHEUS Analytics system (the grouper). The grouper governs what “triggers” or signals the existence of an episode, the logic describing when the episode begins and ends (the time window) and the services to be included in the episode.

The first step in constructing the component episodes is to identify the potential trigger events that initiate these underlying episodes. The episodes within each component of the IPC Arrangement are uniquely defined with their own triggering criteria and time windows based on the nature of the episode (i.e. preventive care, chronic condition, acute medical care, procedure and surgical care, or inpatient and follow-up care for a condition caused by system related failures). System-related failures are those events that occur in the hospital that might have been prevented by better functioning systems, such as nosocomial infections or deep vein thromboses.

The following section summarizes the criteria for the episodes of care within the three components of the IPC Arrangement, including the trigger events, time windows and included service parameters for the episodes. A more detailed review of the episode construction rules, definitions, and trigger code sets is

available on the Altarum Institute’s website.¹

The Underlying Episodes of the IPC Arrangement

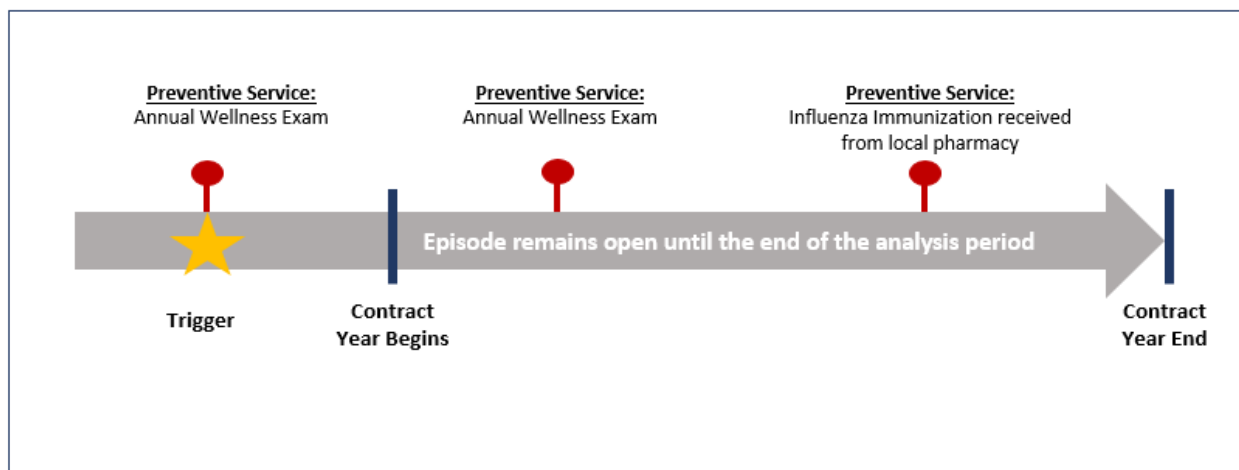
Preventive Care Component

The Preventive Care Component of the IPC Arrangement consists of one episode, called the Preventive Care Episode, which specifically targets services oriented towards prevention.

Preventive Care Episode

- The Preventive Care Episode is initially triggered by a claim for an outpatient or professional office visit with a diagnosis code that is included in the Preventive Care Episode trigger code set.
- The Preventive Care Episode has a time window that is aligned with the contract year. Once triggered in the previous year, the Preventive Care Episode is designed to start at the beginning of the contract year (episode start) and includes all preventive care services delivered from the start of the contract year through the end of the contract year (episode end).
- All preventive care services delivered during the contract year are included in the episode, including: well visits; age-appropriate physical exams; counseling; screenings; immunizations; and, prevention-associated medications.

Figure 2: Preventive Care Episode Example



¹ Details on episode of care definitions and PROMETHEUS Analytics, including information on associated diagnostic and procedure codes, are available on the Altarum Institute’s website ([Link](#)).

Chronic Condition Component

The Chronic Condition Component of the IPC Arrangement includes 14 unique episodes that focus on the care for chronic conditions identified as priorities by the State due to their high prevalence and cost in the NYS Medicaid population. The 14 unique episodes are:

- Arrhythmia/ Heart Block/ Conduction Disorders Episode
- Asthma Episode
- Bipolar Disorder Episode
- Chronic Obstructive Pulmonary Disease Episode
- Coronary Artery Disease Episode
- Depression and Anxiety Episode
- Diabetes Episode
- Gastroesophageal Reflux Disease Episode
- Heart Failure Episode
- Hypertension Episode
- Low Back Pain Episode
- Osteoarthritis Episode
- Substance Use Disorder Episode
- Trauma and Stressors Disorder Episode

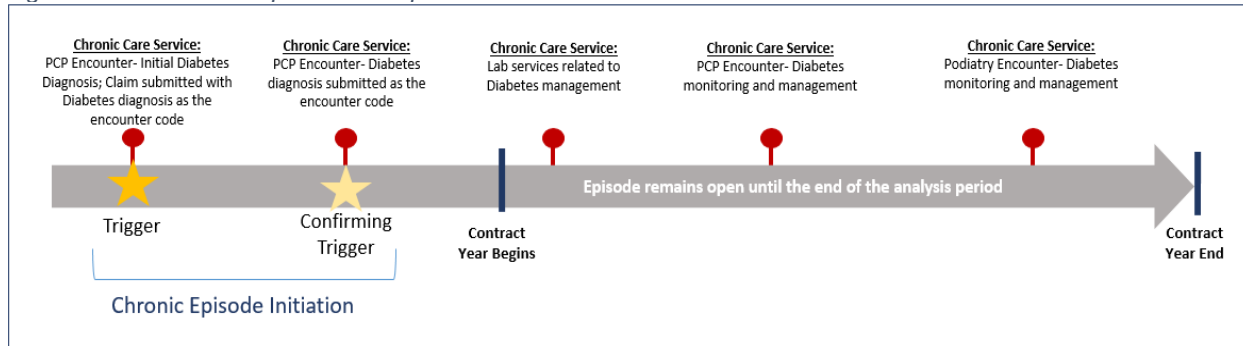
Each episode is defined based on the rules outlined below, along with the episode-specific code sets that can be found on the Altarum Institute's website.² These 14 episodes are not mutually exclusive, and just as a patient can have multiple co-morbidities, he/she can have multiple chronic condition episodes during the year.

Chronic Condition Episodes: 14 episodes based on State-identified priority chronic conditions

- Chronic condition episodes included in the IPC Arrangement must meet the following requirements:
 - 1) The chronic condition episode has an initial triggering claim that occurs prior to the contract year, and, if required, a second confirming claim. The confirmatory claim may be an office visit claim, or a pharmacy claim and can occur at any time, including in the contract year. If the confirming claim is a subsequent office visit it must occur at least 30 days from the initial trigger. A diagnosis code for the condition must be included in each of the claims.
 - 2) The patient receives services related to the chronic condition during the contract year as indicated through submission of at least one claim with a diagnosis for the chronic condition.
- Chronic condition episodes will include all services related to the chronic condition delivered during the contract year.
- Care specific to chronic conditions other than these 14 episodes, such as for Rheumatoid Arthritis, will not be included in this Chronic Condition Component. However, a patient's preventive care and sick care unrelated to Rheumatoid Arthritis will be included in the appropriate episode.
- Due to the requirement for an initial trigger occurring prior to the contract year, patients newly diagnosed with one of the 14 chronic conditions will not have an episode during the year of the initial diagnosis for that condition.

² Ibid.

Figure 3: Chronic Care Episode Example - Diabetes



Sick Care³

The Sick Care Component of the IPC Arrangement includes the following three episodes:

- Allergic Rhinitis/Chronic Sinusitis Episode
- Routine Sick Care Episode
- Upper Respiratory Infection Episode

Allergic Rhinitis/Chronic Sinusitis Episode

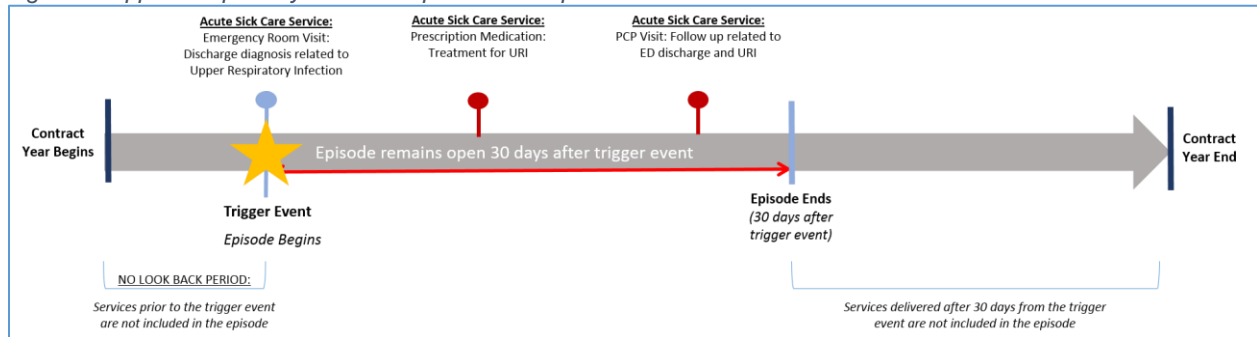
- Consistent with the chronic condition episode logic described above, the Allergic Rhinitis/Chronic Sinusitis Episode is triggered when both an initial triggering event occurs in a year prior to the contract year and the patient receives care related to Allergic Rhinitis/Chronic Sinusitis during the contract year.
- The Episode includes all services delivered for the treatment of Allergic Rhinitis/Chronic Sinusitis during the contract year.

Upper Respiratory Infection Episode

- The Upper Respiratory Infection (URI) Episode is triggered by one or more claims that carry a relevant diagnosis code for acute Upper Respiratory Infection. Due to URI being an acute medical episode, a trigger in the prior year is not required.
- The URI Episode is considered an acute medical episode with a time window limited to 21 days from the service date of the triggering claim. All services relating to treatment of the URI delivered during this 21-day period will be included in the episode.
- A patient can have multiple URI episodes during the contract year. After one URI episode time window ends, a new claim carrying the diagnosis codes for the acute diagnosis of URI will be considered a trigger event opening a second episode with a 21-day time window.

³ Since Measurement Year (MY) 2018, the Tonsillectomy Episode has no longer been included in the grouping for the IPC Arrangement within the Sick Care Component. This decision was made as tonsillectomy procedures are less able to be directly impacted by PCPs. Therefore, providers contracting in an IPC Arrangement are no longer held accountable for the episode costs associated with this procedure.

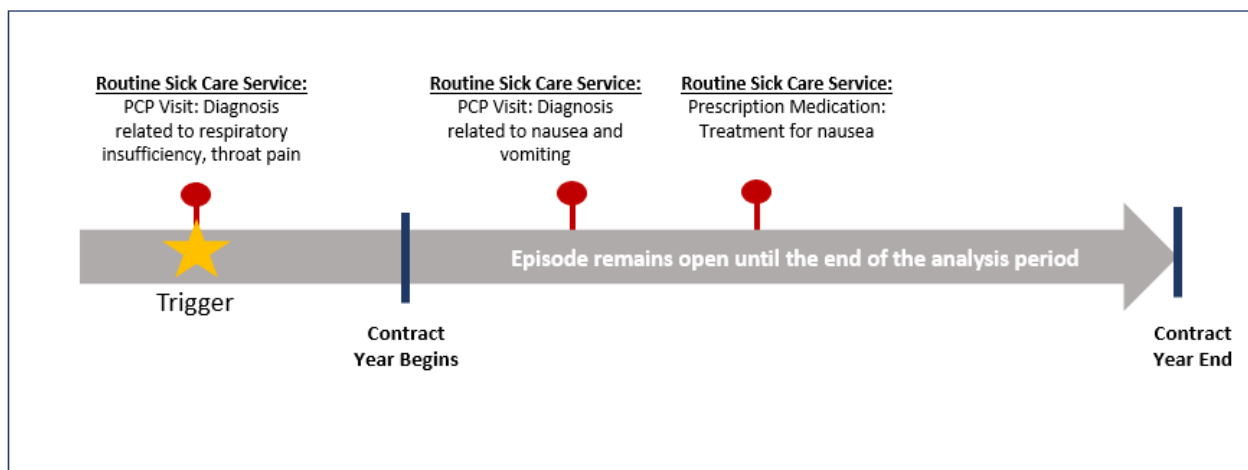
Figure 4: Upper Respiratory Infection Episode Example



Routine Sick Care Episode

- The Routine Sick Care Episode is triggered by one of the following:
 1. An outpatient or professional office visit claim prior to the contract year with a diagnosis code included in the Routine Sick Care code set.⁴ Routine Sick Care trigger code examples include a: diagnosis related to: pain, swelling and/or redness of the eye and other eye inflammation diagnoses; nausea, vomiting, diarrhea, abdominal pain or related diagnoses; joint pain, stiffness and swelling; and, respiratory insufficiency, throat pain or post-nasal drip; or
 2. A triggered URI or Allergic Rhinitis Episode prior to the contract year.
- The Routine Sick Care episode has a time window that is aligned with the contract year. Once triggered in the previous year, the routine sick care episode is designed to start at the beginning of the contract year (episode start), and includes all services delivered from the start of the contract year through the end of the contract year (episode end).
- The Routine Sick Care Episode will include all services directly related to a relevant diagnosis (inpatient, outpatient, ancillary, laboratory, radiology, pharmacy and professional claims) delivered during the contract year.

Figure 5: Routine Sick Care Episode Example



⁴ Details on episode of care definitions and PROMETHEUS Analytics, including information on associated diagnostic and procedure codes, are available on the Altarum Institute's website ([Link](#)).



Patient and Episode Eligibility

Medicaid MCO patients are only included in the IPC Arrangement once they have triggered one of the episodes within the three components of care.

The IPC Arrangement only addresses a subset of services provided to patients based on the services addressed through the three components of care. Accordingly, for each attributed patient, only those services and associated costs captured by the episodes triggered will be included in the Arrangement. For example, a patient who has an established diagnosis of Rheumatoid Arthritis (with no comorbid diagnoses identified) can be included in the Arrangement through the Preventive Care or Sick Care components of the Arrangement. In this example, only those services and costs associated with the Preventive Care and/or Sick Care component episodes triggered by the patient will be included in the Arrangement. The services and associated costs provided to fully manage the patient's Rheumatoid Arthritis diagnosis will not be included in the Arrangement.

Additionally, episodes for patients meeting the following criteria **will be excluded**:

- **Medicaid patients for whom Medicaid is not the sole payer:** Medicaid patients with contract year claims or encounters for which Medicaid is not the sole payer are excluded (e.g. dually eligible patients and patients with Medicaid as the payer of last resort on a commercial premium)

The IPC Arrangement does not include additional requirements related to utilization of specific services or historical diagnostic information to be eligible for inclusion in the Arrangement. Patients who are non-utilizers (those who do not seek services (including prescription drugs) during the year) are included in the eligible patient population count and attributed to the PCP as outlined below. These patients will not contribute to the total cost calculation for the IPC Arrangement, but are included for tracking and quality purposes.

Patient Attribution

Medicaid patient attribution defines the group of patients for which a VBP Contractor is responsible in terms of quality outcomes and costs. For member attribution to occur in any arrangement, a Medicaid covered recipient must be enrolled for three or more consecutive months with a managed care plan. The NYS Roadmap details attribution guidelines for VBP Contractors and Medicaid MCOs for each arrangement.⁵

New York State's guidance for attribution under the IPC Arrangement is to attribute patients based on the Medicaid MCO-assigned PCP. However, an MCO and VBP Contractor may agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.

Calculation of Episode Costs

Once the episodes for the IPC Arrangement have been constructed for the attributed population, the costs within each of the underlying episodes (defined as the total amount paid by the Medicaid MCO for episode services) will be combined to produce a total cost of care for the Arrangement.

The aggregate costs can be further analyzed to identify and understand variation across the underlying episodes and by service type, leading to opportunities for improvement in quality of care and resource use.

⁵ New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, November 2017: Year 3, New York State Roadmap for Medicaid Payment Reform, November 2017, p. 23. ([Link](#))



Section 2: VBP Quality Measure Set for the IPC Arrangement

The 2019 IPC Quality Measure Set was developed drawing on the work of stakeholder groups convened by the Department of Health (DOH) to solicit input from expert clinicians around the state. The physical health measures were drawn from the measure sets developed by the Diabetes, Chronic Heart Disease and Pulmonary Clinical Advisory Groups (CAGs) and from the measures recommended for Advanced Primary Care (APC) by the Integrated Care Workgroup. Likewise, the behavioral health measures were drawn from the measure sets developed by the Behavioral Health CAG.

The State is recommending a full complement of physical and behavioral health measures to help ensure attributed patients receive high quality physical and behavioral health care. Measures recommended by the CAGs were submitted to NYS DOH, the Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) for further feasibility review and, ultimately, to the VBP Workgroup who are responsible for overall VBP design and provide final approval. During the final review process, the IPC quality measure set was aligned with existing Delivery System Reform Incentive Payment (DSRIP) Program, Quality Assurance Reporting Requirements (QARR) measures and measures utilized by Medicare and Commercial programs in NYS, where appropriate.

Historically, the VBP Quality Measure Sets for IPC and Total Care for the General Population (TCGP) Arrangements have been the same. During the 2018 Measure Review Cycle, the Children's Health CAG recommended adding several maternity specific measures to the TCGP Quality Measure Set to better reflect the inclusion of maternity care in TCGP arrangements. These measures were not added to the IPC Quality Measure Set due to the focus on primary care in IPC arrangements. As a result, there are now separate VBP Quality Measure Sets for TCGP and IPC Arrangements

Measure Classification

In September and October of 2016, the CAGs published their initial recommendations to the State on quality measures support required for providers to be successful in improving the financial sustainability of NYS' safety net. These reports also addressed other implementation details related to VBP IPC Arrangements. Upon receiving the CAG recommendations, the State conducted a further review of measure feasibility to define a final list of measures for inclusion during the 2017 VBP Measurement Year (MY). Each measure was designated by the State as Category 1, 2 or 3 according to the following criteria:

- **CATEGORY 1** – Approved quality measures that are deemed to be both clinically relevant, reliable, valid and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid and reliable, but where the feasibility could be problematic. These measures were further investigated during the 2017 & 2018 VBP Pilot programs; and,
- **CATEGORY 3** – Measures that are insufficiently relevant, valid, reliable and/or feasible.

Note that measure classification is a State recommendation. Although Category 1 Measures are required to be reported, Medicaid MCOs and VBP Contractors can choose the measures they want to link to payment and how they want to pay on them (P4P or P4R) in their specific contracts.



Category 1

Category 1 quality measures, as identified by the CAGs and accepted by the State, are to be reported by VBP Contractors. These measures are also intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.⁶

The State classified each Category 1 measure as either P4P or P4R:

- **P4P** measures are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.⁷ In other words, these are the measures on which payments in VBP contracts may be based. Measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors; and,
- **P4R** measures are intended to be used by the Medicaid MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to patients under the VBP contract. Incentives for reporting should be based on timeliness, accuracy, and completeness of data. Measures can be reclassified from P4R to P4P through annual CAG and State review or as determined by the Medicaid MCO and VBP Contractor.

Not all Category 1 measures will be reportable for Measurement Year 2019, as reporting on some of these measures will be phased in over the next 2 years. Please see the Value Based Payment Reporting Requirements Technical Specifications Manual for details as to which measures must be reported for the Measurement Year.⁸ This manual will be updated annually each Fall, in line with the release of the final VBP measure set for the subsequent Measurement Year.

Categories 2 and 3

Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability, but flagged as presenting concerns regarding implementation feasibility. The State required VBP Pilots to select and report a minimum of one Category 2 measure per VBP arrangement for MY 2018 (or have a State and Plan approved alternative). VBP Pilot participants are expected to share meaningful feedback on the feasibility of Category 2 measures when the CAGs reconvene during the Annual Measure Review.

Measures designated as Category 3 were identified as unfeasible. Reasons include use in small sample sizes of attributed patients at a VBP Contractor level, and limited potential for performance improvement in areas where statewide performance is already near maximum expected levels. These Category 3 measures will not be tested in pilots or included in VBP arrangements in 2019.

Annual Measure Review

Measure sets, and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, re-categorization and re-classification from P4R to P4P, or P4P to P4R, based on experience with measure implementation in the prior year. During 2019, the CAGs and the VBP Workgroup will re-evaluate measures and provide recommendations for MY 2020. A full list of the 2019 IPC measures is located in the NYS VBP Resource Library on the DOH website.⁹

⁶ Ibid, p. 34.

⁷ Ibid.

⁸ 2019 Value Based Payment Reporting Requirements; Technical Specifications Manual, November 2018, File is located in the Quality Measures tab of the VBP Resource Library ([Link](#))

⁹ NYS Delivery System Reform Incentive Payment (DSRIP) - VBP Resource Library ([Link](#))



Appendix 1: VBP Glossary



VBP Glossary

- **Diagnosis codes:** These are codes (as defined in the PROMETHEUS grouper) based on the International Classification of Diseases (ICD) that are used to group and categorize diseases, disorders, symptoms, etc. These codes help identify clinically related services to be included in the episode in conjunction with the relevant procedure codes. These codes may include trigger codes, signs and symptoms and other related conditions and are used to steer services into an open episode.
- **Episode of Care:** An Episode of Care includes groups of clinically related services (as defined in the PROMETHEUS Analytics grouper) delivered by physicians and ancillary providers across multiple settings of care during a defined period.
- **Grouper: PROMETHEUS Analytics system.** The rules for each episode are programmed into an analytic tool that runs on claims data in a systematic fashion. The analytic program – the grouper – governs what starts or “triggers” an episode, the length of time an episode will run and the kinds of services that are grouped together to form the episode.
- **Included Service:** A service that is pulled into an episode by the PROMETHEUS Analytics system grouper is an included service.
- **Initial and Confirming Triggers:** An initial trigger initiates an episode based on diagnosis and/or procedure codes found on institutional or non-institutional claims data. For many episodes, a second trigger (the confirming trigger) is necessary to initiate the episode in the contract year. Sometimes an episode itself could serve as a trigger for another episode, for example, the URI episode is a trigger for the Sick Care episode.
- **Look Back & Look Forward:** From the point in which an episode is triggered, episode costs and volume are evaluated within the associated time window for a predetermined number of days before and after the trigger date. Costs, volume and other episode components that fall within this range are captured within the episode.
- **Pharmacy codes:** These are codes used to identify relevant pharmacy claims to be included in the episode. The PROMETHEUS Analytics system groups pharmacy National Drug Codes (NDC) into higher categories using the National Library of Medicine’s open-source RxNorm drug classification system.
- **Procedure codes:** These are codes used to identify clinically-related services to be included in the episode in conjunction with the typical diagnosis codes. Procedure codes include International Classification of Diseases (ICD) procedures, Healthcare Common Procedure Coding System (HCPCS), and Current Procedural Terminology (CPT) codes.
- **Time-window:** This is the time that an episode is open for analytic purposes. It may include the trigger event, a look-back period, and a look-forward period and could extend based on rules and criteria.
- **Trigger code:** A trigger code assigns a time window for the start and end dates of each episode (depending on the episode Type). Trigger codes can be ICD diagnosis or procedure codes, CPT codes or HCPCS codes, and could be present on an inpatient facility claim, an outpatient facility claim or a professional claim.



- **VBP Contractor:** An entity – either a provider or groups of providers – engaged with a Medicaid MCO in a VBP contract.